BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
PAYAM MOAZZAZ, M.D.	)	Case No. 800-2016-020346
Physician's and Surgeon's Certificate No. A100652	)	OAH No. 2018040774
Respondent	)	

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on January 25, 2019.

IT IS SO ORDERED: December 26, 2018.

MEDICAL BOARD OF CALIFORNIA

Kristina Lawson, JD, Chair
Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: PAYAM MOAZZAZ, M.D., Physician's and Surgeon's Certificate No. A100652, Respondent.	Case No. 800-2016-020346 OAH No. 2018040774

PROPOSED DECISION

Abraham M. Levy, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on October 8 through 11, 2018, in San Diego, California.

Jason J. Ahn, Deputy Attorney General, State of California, represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California.

David M. Balfour, Attorney at Law, Nossaman LLP, represented respondent, Payam Moazzaz, M.D., who was present.

The matter was submitted on October 11, 2018.[1]

SUMMARY

Complainant asserted that respondent's license should be subject to discipline. Clear and convincing evidence established that respondent violated Business and Professions Code sections 2234, subdivision (b), gross negligence; 2266, failure to maintain adequate and

[1]On the Administrative Law Judge's own motion, a protective order was issued sealing AGO pages 1385 to 1397 of Exhibit 13, port-mortem photos of Patient A. A copy of this order was served on the parties. A reviewing court, parties to this matter, and a government agency decision maker or designee under Government Code section 11517 may review materials subject to the protective order provided that this material is protected from disclosure to the public.

accurate records; and 2234, unprofessional conduct in his treatment and care of Patient A on July 31, 2014. Respondent showed that he is sufficiently rehabilitated that a period of probation with appropriate terms and conditions will ensure public protection.

FACTUAL FINDINGS

Jurisdiction

1. On March 21, 2018, Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board), filed the Accusation in this matter. Respondent timely filed a Notice of Defense and Objection to the Accusation.

The Accusation alleges that respondent committed gross negligence and repeated negligent acts; failed to maintain adequate or accurate records; and committed general unprofessional conduct in his care and treatment of Patient A. The Accusation also alleges he committed repeated negligent acts, engaged in unprofessional conduct, and failed to maintain adequate or accurate records in his preparation of Qualified Medical Evaluator (QME) reports for Patient B.

The Accusation specifically asserts that respondent's medical records "reflecting Patient A's follow up visit with him," on July 31, 2014, which stated "her [Patient A's] surgical incision is healing well with no erythema or drainage" was false, he had inadequate communication with Patient A's skilled nursing facility after her hip surgery, he provided Patient A with inadequate follow up care after her hip surgery, and he "mixed up" medical records belonging to another patient or patients with Patient B's medical records in his review and/or drafting of reports as a QME for Patient B's workers' compensation claim.

License History

2. On July 1, 2007, the Board issued Physician's and Surgeon's Certificate Number A100652 to respondent. The certificate is current and will expire on July 31, 2019, unless renewed. Respondent has no history of discipline.

Prehearing Motions

3. Both parties filed motions in limine that were addressed the first day of the hearing. Complainant filed a motion in limine to exclude the testimony of respondent's expert, Jeffrey Deckey, M.D., because, complainant asserted, complainant had not filed "any expert report" as required by Business and Professions Code section 2334, subdivision (a). Respondent filed a motion in limine to dismiss that portion of the Second Cause for Discipline relating to Patient B because the Division of Workers' Compensation of the Department of Industrial Relations has a disciplinary process in place for QMEs, respondent did not treat Patient B but served as a QME for Patient B, and the Board lacks jurisdiction to

address respondent's evaluation of Patient B. After giving due consideration to their arguments, the parties' motions were denied.

Summary of Patient A

4. Patient A was a 91-year-old widow when she became respondent's patient for a hip surgery he performed on July 9, 2014. The relevant background to this surgery is as follows: On July 1, 2014, after she fell a few times in her home, her son and daughter decided to move her to an assisted living facility. The patient had been using a walker for the previous five years. On July 7, 2014, around 10:00 p.m., Patient A lost her balance at the assisted living facility and fell down without losing consciousness. She was taken to Tri-City Medical Center's Emergency Department, where she complained of contralateral right hip pain and a laceration of the left elbow, while the clinical condition was in the left hip. X-rays of the left hip, pelvis, left knee, left elbow, and chest were obtained, and the patient was noted to have a Garden II displaced left femoral neck fracture.

5. On July 8, 2014, Patient A was admitted to the hospital and respondent saw her in consultation. Respondent noted the left leg to be shortened and externally rotated with mild tenderness over the greater trochanter. Upon reviewing her imaging studies, he recommended a left hip hemiarthroplasty surgical procedure. Her white cell count at the time was 12.5 with low sodium and chloride levels. She was evaluated by Minh Nguyen, M.D., hospitalist, and was noted to have hypovolemic hyponatremia with a left femoral neck fracture and left elbow laceration. Among her other medical issues, she also had chronic cerebellar ataxia, benign hypertension, hyperlipidemia, mild cognitive dysfunction, and anxiety disorder with a history of sinus node dysfunction, a pacemaker, right breast cancer post mastectomy, and a history of urinary incontinence.

6. On July 9, 2014, under general endotracheal anesthesia, respondent performed left hip un-cemented hemiarthroplasty surgery on Patient A. Respondent irrigated the surgical wound with vancomycin powder, an antibiotic to prevent infection, before closure of the fascial layer. The wound was again irrigated, and antibiotic solution and vancomycin powder were placed in the wound bed above the fascial layer. Skin staples were used to approximate the skin edges.

7. After her surgery, on July 10 and 11, 2014, hospital nurse practitioner Rachel Anderson discussed Patient's A's post- operative status with respondent in notes she recorded. Ms. Anderson documented that she told respondent Patient A was doing well.

8 Patient A was hospitalized until July 12, 2014. On this date, she was transferred to Vista Knoll Specialized Care Center, a skilled nursing facility (facility or Vista Knoll), where general practitioner Houssam Baroudi, M.D., was the medical coordinator.

9. On July 18, 2014, an unidentified medical doctor visited Patient A and ordered "FeSu" and a "hemogram" in two weeks.[2] The record did not document whether this doctor examined respondent's surgical site.

10. On July 22, 2014, she was noted to have a small bruise on the inner aspect of her left buttock, but the latter was felt to be expected secondary to her being on heparin. She was given Norco 10/325 tablets to take on an as needed basis.

11. On July 24, 2014, around 10:00 a.m., Patient A's physical therapist called the nurse at the skilled nursing facility and advised her that Patient A had bleeding from her left hip incision site. Upon inspection, the nurse noted that Patient A had a moderate amount of serosanguinous fluid dripping from her incision site and on the bandage.[3] The incision site was red, slightly raised, and well approximated with all staples intact. No streaking, warmth, fever, or swelling around the wound site was noted. Patient A complained of pain about the left hip but not increased pain on palpation. Her temperature was 98.6 degrees Fahrenheit. The nurse notified Dr. Baroudi and a complete blood count, blood metabolic panel, and urinalysis were requested. Respondent was also notified, and he ordered Keflex 500 mg, an antibiotic, one tablet four times per day for seven days.

12. At 11:29 p.m., on July 24, 2014, the nurse noted Patient A's left hip wound to be red, warm, and draining red serosanguineous fluid, with yellow pus at the incision site; the bandages were soaked through. Local wound care was performed.

13. On July 25, 2014, at 2:09 a.m., the facility nurse again noted the presence of left hip infection at the incision site. The affected area was kept dry and clean with dressings. Patient A's temperature was 98.7 degrees Fahrenheit.

14. At around 11:00 a.m., on July 25, 2014, Patient A's dressings were again changed and by 4:12 p.m. the same day, she was noted to still have fluid draining from the incision site. She complained of no pain in her left hip, except when moved. Her temperature was 99.6 degrees Fahrenheit, and x-rays of the left hip were obtained on the same day which did not show abnormalities referable to the hemiarthroplasty.

15. At 11:00 p.m. on July 25, 2014, the dressings were changed. By July 27, 2014, urine cultures were noted to have grown E. coli and enterococcus bacteria. Dr. Baroudi decided to start her on Cipro tablets for seven days and discontinue the Keflex tablets that were started for the left hip infection.

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[2] FeSu is the abbreviation for Iron Sulfate, a tablet used to treat iron deficiency. Hemogram is a complete blood count.

[3] Serosanguineous means containing or relating to both the blood and liquid part of the blood.

16. On July 27, 2014, at around 4:36 p.m., a certified nursing assistant noted a small skin tear on the left inner buttock and by July 29, 2014, there was an area of denuded skin on the left buttock measuring 6.5 x 1.7 cm. Patient A was still incontinent, and she was afebrile at 96.8 degrees Fahrenheit.

17. On July 30, 2014, just past midnight, Patient A was noted to be picking at or moving her hip surgery site when asleep in bed. Her temperature at 6:11 a.m. on the same morning was 98.9 degrees Fahrenheit.

18. By 8:29 a.m. on July 30, 2014, her left hip pain level was reported at the 8 out of 10 level.

19. On July 31, 2014, Patient A went to respondent's office with her son so that respondent could examine the surgical site.

20. Before the July 31, 2014 appointment, no medical doctor was documented to have evaluated Patient A's left hip wound since her discharge from Tri-City Medical Center (Tri-City). Respondent documented this visit with Patient A in a report he prepared captioned "Post-operative follow-up" dated July 31, 2014.

21. In this report, apparently based on an examination he performed of Patient A, respondent reported that "she has not had any fevers or drainage." The report, further, documented that Patient A was afebrile with her surgical incision healing well with no erythema or drainage.

Respondent's report was not accurate, however. He did not examine Patient A's surgical site and the notes that reported "she has not had any fevers or drainage" and her surgical incision was healing well with no erythema or drainage were incorrect. As respondent acknowledged in his testimony at this hearing, respondent did not examine Patient A because Patient A's son insisted that he did not want her to be removed from her wheelchair due to her discomfort and because she wanted to return to the skilled nursing facility. Instead of conducting his own examination of Patient A, respondent relied on Patient A's son's report that "she has not had any fevers or drainage." Respondent did not document that Patient A's son gave him this information and he, further, did not document that her son did not want her examined.

As his plan for treatment at the skilled nursing facility, respondent issued an order for the skin staples to be removed and Steri-Strips applied with the patient to return in four weeks for repeat hip x-rays and continue physical therapy and gait training. He reviewed her imaging studies and found no hemiarthroplasty implant complications or loosening.

22. Upon her return to the skilled nursing facility at 5:27 p.m. on July 31, 2014, Patient A complained of severe pain in her hip at an 8 out of 10 level; she was given Norco 10/325-mg tablets. By 9:45 p.m. of July 31, 2014, she was complaining of severe pain at an 8 out of 10 level and she was given Norco 10/325-mg tablets to address her pain.

23. By August 1, 2014, at 3:15 a.m., Patient A's pain level increased to a 9 out of 10 level and by 6:16 a.m., her wound was still draining. By 7:49 a.m., the incision site was oozing serosanguinous drainage and half of the staples were removed.

24. By 9:26 a.m. on August 1, 2014, respondent's office was notified of the condition of the incision site and the drainage. Respondent, however, was not available at this time because on August 1, 2014, he had left town for a 10-day vacation. On August 1, 2014, Dr. Baroudi ordered the patient to be transferred to Tri-City Medical Center's Emergency Department for further care.

25. At about 5:19 p.m. of August 1, 2014, Patient A presented to Tri-City Medical Center's Emergency Department. Her white blood count had significantly increased to 20.9, indicating that she had an infection, and she had 38.6-degree centigrade temperature [101.48 degrees Fahrenheit]. Her left hip incision site showed significant copious saturated drainage with foul odor and new wound cultures were obtained. A wound culture collected from Patient A on August 1, 2014 showed the presence of Methicillin Resistant Staphylococcus aureus.[4] Respondent's associate, David Amory, M.D., evaluated her, and she was noted to have frank wound dehiscence with the wound draining focal purulent drainage. X-rays of the left hip showed the hemiarthroplasty to be in good position. He advised irrigation and debridement and removal of the prosthesis with primary exchange. The family consented to the surgery. Patient A was admitted to the hospital.

26. At the hospital her blood pressure significantly dropped, her condition deteriorated, and she was no longer a surgical candidate. Pursuant to a "do not resuscitate" request during both hospitalizations, the family wanted her to only have comfort measures. A Foley catheter was inserted, and she was started on morphine infusion. Patient A expired in the hospital on August 3, 2014, at 9:25 p.m.

Summary of Patient B[5]

27. On August 29, 2015, respondent examined Patient B as a QME with the Division of Workers' Compensation of the Department of Industrial Relations for purposes of her workers' compensation claim. QMEs are qualified physicians who are certified by the Division of Workers' Compensation - Medical Unit to examine injured workers to evaluate

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[4] The lab test is dated August 2, 2014.

[5] Patient B is identified as a "Patient" here only because this is how she is identified in the Accusation. As discussed later in this decision there is an issue whether Patient B was respondent's patient for purposes of application of the standard of care complainant's expert identified.

disability and write medical-legal reports.[6] The reports are used to determine an injured worker's eligibility for workers' compensation benefits.

Patient B had two reported dates of injuries, January 17, 2013, and September 25, 2013, related to motor vehicle accidents. After the QME evaluation, respondent signed a report on September 6, 2015, which mistakenly listed 14 medical providers who never saw Patient B. Thereafter, when the above deficiency was raised, respondent submitted a revised report dated July 8, 2017, in an effort to address the mistake.

However, this revised report still included three medical providers who were not related to Patient B's care. Respondent signed a second revised report on December 25, 2017, where he removed the sentence that identified the three incorrect doctors.

In each of the three reports that respondent prepared, in the first section, respondent stated that he was performing a medical legal evaluation, was not determining the treatment to be given and was not acting in a treatment capacity.

The section in each of the reports reads as follows:

> The medical-legal evaluation is based only on the current information and records submitted. It is solely the treating physician's responsibility to determine their patient's differential diagnoses and subsequent needs for medical treatment. This would be inclusive of all psychiatric conditions, vascular diseases, neuromuscular disorders, central nervous system disorders, auto-immune diseases, internal medicine disorders and all tumors, benign or malignant, even if they are undiagnosed or currently occult.

Also, in each of the reports respondent signed an attestation that the information in the reports was true and correct to the best of his knowledge.

Testimony of Experts Regarding Patient A

TESTIMONY OF COMPLAINANT'S EXPERT JOHN MISSIARIAN, M.D., REGARDING PATIENT A

28. John Missiarian, M.D., obtained his Medical Degree from American University of Beirut in 1975, and completed residencies at the Medical College of Ohio, St. Luke's Hospital in Cleveland, in general surgery and in orthopedic surgery and fellowships in Diabetic Foot and Amputee Rehabilitation and Adult Reconstruction Foot and Ankle in 1981 and 1982. Since 1983, Dr. Missiarian has been Chairman of the Department of Orthopedic

[6] <https://www.dir.ca.gov/dwc/MedicalUnit/QME_page.html> [as of October 19, 2018.]

Surgery at Seton Medical Center in Daly City, California. From 1983 to 1995, he held teaching appointments at San Francisco Orthopedic Residency. He is board certified by the American Board of Orthopedic Surgery.

Dr. Missiarian reviewed the medical records and other materials, which were entered into evidence in this matter, and based on his review of this information, testified concerning whether respondent departed from applicable standards of care in his care and treatment of Patient A. Dr. Missiarian prepared a report summarizing his review and conclusions regarding respondent's care of Patient A, which was admitted into evidence and was consistent with his testimony.

Dr. Missiarian identified two areas where respondent's care and treatment of Patient A departed from applicable standards of care: Documentation and Communication/Follow-Through.

He identified the applicable standard of care for documentation as follows: The treating physician is supposed to document his/her findings as soon as feasible and without delay so that they are fresh in the treating physician's mind and are true reflections of the clinical findings. These findings should reflect the treating physician's honest findings and impressions.

Dr. Missiarian found that respondent departed from this standard in two respects: He did not examine Patient A's left hip wound from the surgery he performed when he saw Patient A on July 31, 2014, and thus, his July 31, 2014, office visit note that "her surgical incision is healing well with no erythema or drainage" was not accurate.

He concluded that respondent's failure to accurately document his July 31, 2014, examination of Patient A was an extreme departure because it did not accurately reflect the condition of Patient A's wound, which he did not examine. Dr. Missiarian emphasized here that clear documentation was important because respondent was seeing Patient A for the first time since she left the hospital on July 12, 2014, and he was seeing her to examine her wound to see if it was healing well after having been told there were signs of infection. Dr. Missiarian stressed that accurate record keeping is important for a subsequent clinician to have correct information to treat a patient.

Dr. Missiarian also found that respondent departed from the documentation standard of care when he failed to co-sign the July 10 and 11, 2014, post-operative follow-up notes which Nurse Practitioner Anderson prepared. He concluded that his failure to cosign the record was a simple departure from the standard of care because it was unclear if Ms. Anderson had respondent's full approval when she generated these two notes.

Dr. Missiarian identified the second standard of care that respondent violated as follows: When an orthopedic surgeon meets a trauma victim, he or she has several duties: They include making the appropriate diagnosis, advising on the correct surgical approach, performing the surgery in a skillful fashion, and following the patient's postoperative care

until recovery and full rehabilitation of the patient. If the orthopedic surgeon has chosen to have assistance in these tasks, and if other health providers are also involved in the course of the patient's recovery, the orthopedic surgeon is required to coordinate care. This is because the well-being of the patient is the surgeon's responsibility, with the final decision resting on his or her shoulders. Issues that are outside the realm of orthopedic surgery and the well-being of the patient in those circumstances fall on the shoulders of medical doctors who are also involved in the care of the same patient. However, all health providers involved in the care of the patient should have a method of communication for the overall well-being of the patient involved. Close follow-up care and supervision by the treating orthopedic surgeon during the immediate postoperative period are very critical and necessary. The patient who has been transferred to a skilled nursing facility is still within that critical period of time that requires active and ongoing supervision by the treating surgeon. Orders given to the nursing staff need to be followed through by the ordering orthopedic surgeon to make sure that those orders are carried out appropriately for the well-being of the patient.

Dr. Missiarian concluded that respondent committed an extreme departure from this standard of care because he did not establish adequate communication with the skilled nursing facility to follow Patient A's progress post-surgery to ensure she received adequate post-surgical care. Dr. Missiarian reached this conclusion because the rate of morbidity and mortality is very high for an elderly patient such as Patient A after hip surgery and respondent failed to adequately follow her progress. He testified that as Patient's A's surgeon, respondent needed to "create communication" with the skilled nursing facility for Patient's A's welfare.

Dr. Missiarian was asked about respondent's expert, Dr. Jeffrey Deckey's, anticipated testimony, as summarized in the report Dr. Deckey prepared, regarding respondent's care and treatment of Patient A. Specifically, he was asked to address Dr. Deckey's opinion that respondent's failure to inspect the wound was a simple departure because Patient A's son did not want him to inspect the wound because Patient A was upset and wanted to return to the skilled nursing facility. Dr. Missiarian disagreed with Dr. Deckey's conclusion in this respect. He emphasized that the purpose of Patient A's July 31, 2014, visit was for respondent to examine the wound. He noted that respondent could have tried to look at the wound while Patient A was in the wheelchair and he could have tried to convince her and her son to allow him to examine the wound considering the importance of the visit to inspect the wound. In any event, Dr. Missiarian stated that respondent should have accurately reported that he did not inspect the wound because Patient A and her son did not want him to inspect it.

Dr. Missiarian was also asked to address Dr. Deckey's anticipated testimony that respondent could rely on other clinicians regarding Patient A's post-operative status and was not responsible for the fact that clinicians at the skilled nursing facility, including Dr. Baroudi, did not provide respondent with all the information regarding Patient A's infection and condition.

Dr. Missiarian again disagreed with Dr. Deckey. He responded that communication is a two-way street and, as "captain" of Patient A's musculoskeletal care, it was respondent's duty to follow-up. Here, Dr. Missiarian commented that respondent skillfully cared for Patient A pre-operatively and skillfully performed the surgery. But, he again emphasized that as the surgeon he needed to "create" communication between the skilled nursing facility because he was responsible for her musculoskeletal condition.

TESTIMONY OF RESPONDENT'S EXPERT, JEFFREY DECKEY, M.D., REGARDING PATIENT A

29. Jeffrey Deckey, M.D., obtained his Medical Degree from Columbia University College of Physicians and Surgeons in New York in 1992. He completed an Orthopedic Residency at the New York Orthopedic Hospital, Columbia-Presbyterian Medical Center from 1993 to 1997 and a Spine Surgery Fellowship at the University of California, San Francisco from 1997 to 1998. He is Director of Complex Spine Surgery at St. Joseph's Hospital in Orange, California and since 2016 he has been Managing Partner at Orthopedic Specialty Institute, where he has been a partner since 1992. He is the author of a number of publications in orthopedic medicine, been a presenter on topics related to orthopedic medicine, and been a participant in studies in the field of orthopedic surgery.

Dr. Deckey reviewed the evidence of record in this matter relating to respondent's treatment of Patient A and prepared a report. His testimony was consistent with his report.

Regarding Dr. Missiarian's opinion that respondent committed an extreme departure due to his failure to inspect Patient A's surgical site, Dr. Deckey agreed that respondent's failure to inspect the wound represented a departure from the standard of care. He acknowledged that the purpose of the post-op visit was to inspect the site and assess Patient A's pain level and functioning status. Dr. Deckey believed that respondent should have acted against Patient A's son's wishes and pushed to perform the examination of the wound. As Dr. Deckey commented, "unfortunately" respondent gave-in to Patient A's son's resistance and did not see Patient A's wound.

However, Dr. Deckey believed that his failure to inspect the site represented a simple, as opposed to an extreme departure, from the standard of care. He provided the following reasons for this conclusion: Respondent's care of Patient A did not represent "the want of even scant care." At Dr. Deckey's practice, hip surgeons see patients post hip surgery after six weeks in contrast to the two weeks when respondent saw Patient A, and surgeons at his practice rely on a nurse practitioner or nurse to take out the staples. It was "reasonable" for respondent to rely on Patient A's son's history of fever and drainage. Dr. Deckey added that he did not believe that Patient A had a fever but had drainage.[7] He noted that respondent also

[7]Oddly, there was no documentation indicating that Patient A's temperature was taken during the July 31, 2014, visit. Thus, Dr. Deckey's opinion that Patient A did not have a fever is without basis because the medical records indicate that her temperature was not taken on July 31, 2014.

reviewed the x-ray of Patient A's implant's position. Dr. Deckey also added that the skilled nursing facility did not notify respondent between July 24 and 31, 2014, of her condition.

Dr. Deckey further opined that respondent's failure to inspect the wound or accurately document that he failed to do so constituted a single event and not separate departures from the standard of care. He stated that the departure flowed from respondent's failure to examine Patient A's wound. He cited the Board's Expert Reviewer Guidelines for support regarding his opinion that when a simple departure is a single act as opposed to separate and distinct acts per Business and Professions Code section 2234, subdivision (c).

Regarding respondent's failure to communicate and follow up with Patient A's clinicians at the skilled nursing facility, Dr. Deckey disagreed with Dr. Missiarian's conclusion that respondent departed from the standard of care. Dr. Deckey stated that respondent acted within the standard of care because he had the right to rely on clinicians at the skilled nursing facility to inform him of Patient A's status and the standard of care did not require him to call the facility after July 24, 2014. He stated calling was just not "practical" and that it could result in conflicts with the facility doctor in prescribing medications, including antibiotics.

Dr. Deckey elaborated on his opinion in this regard: As an orthopedic surgeon in the community, there is the expectation that if an elderly hip surgery patient develops drainage with yellow puss or has a white blood count of 12.9, as was Patient A's case on July 24, 2014, the doctor who ordered the white blood count should notify the surgeon. Dr. Deckey commented that elderly patients go to skilled nursing facilities because treatment protocols are in place, and wound nurses who work there who are experienced and responsible for contacting the surgeon when there is a progressive problem with the wound. Based on his experience, Dr. Deckey expressed frustration that elderly patients may be better off at home with families who monitor them than at some skilled nursing facilities with inconsistent monitoring.

30. Dr. Deckey also addressed Dr. Missiarian's testimony that respondent departed from the standard of care when he failed to co-sign Nurse Practitioner Anderson's July 10 and 11, 2014, notes. He said that the standard of care does not require that physicians co-sign notes of nurse practitioners and that Ms. Anderson acted within the standard of care in preparing the note indicating that she consulted with respondent on July 10 and 11, 2014. Dr. Deckey stated that a physician needs to sign only five percent of such notes as long as there is an agreement with the practitioner. Complainant did not dispute Dr. Deckey's testimony in this regard.

Evaluation Regarding the Experts' Testimony Regarding Patient A

31. Drs. Missiarian and Deckey were both credible highly qualified witnesses and they expressed their opinions in a thoughtful, dispassionate and clear manner. In resolving the conflicts in their testimony, their opinions must be weighed against each other consistent with the record. In doing so, consideration has been given to their qualifications and

believability, the reasons for their opinions, and the factual basis of their opinions. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.)

With due consideration to these factors, Dr. Missiarian's testimony is found to be more persuasive than Dr. Deckey's in certain respects, while Dr. Deckey's testimony is more persuasive than Dr. Missiarian's in other respects.

Regarding respondent's failure to examine Patient A on July 31, 2014, Dr. Missiarian's testimony here is found to be more persuasive than Dr. Deckey's opinion for the following reasons: Both experts acknowledged that the purpose of Patient's A's July 31, 2014, office visit was for respondent to examine her wound after her surgery. Both experts acknowledged that it was important that respondent examine her wound to assess whether it was infected. Both experts further acknowledged that Patient A was at a high risk of morbidity due to her age after her hip surgery. Thus, considering the risk Patient A faced as a 91-year-old post-hip-surgery patient, respondent should have examined Patient A's wound to mitigate against the risks she faced. His failure to examine her wound, or try to convince her and her son of its importance, cannot be deemed a simple departure from the standard of care, as Dr. Deckey stated. It was an extreme departure from the standard of care as Dr. Missiarian found.[8] ("Negligence and gross negligence are relative terms. 'The amount of care demanded by the standard of reasonable conduct must be in proportion to the apparent risk. As the danger becomes greater, the actor is required to exercise caution commensurate with it.'" (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal. App. 3 d 184, 198, citing Prosser, Law of Torts (4th ed. 1971) at p. 180.))

Regarding the question whether respondent committed an extreme departure from the standard of care when he failed to accurately document that he did not examine Patient A, Dr. Missiarian's testimony is again credited over Dr. Deckey's testimony. Dr. Missiarian credibly testified that respondent failed to document Patient A's "true reflections of the clinical findings" because his records inaccurately stated that "her [Patient A's] surgical incision is healing well with no erythema or drainage." Considering her condition and the need for a subsequent clinician who may read this note to have an accurate picture of Patient A's condition to treat her, Dr. Missiarian correctly assessed the level of departure from the standard of care as extreme.[9]

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[8] That Patient A's wound was infected on July 31, 2014, highlights the risk Patient A faced and the importance of the examination respondent was scheduled to perform for purposes of assessing the level of departure. With this noted, Dr. Missiarian stated in his testimony that there is no way to assess whether the Patient A's outcome would have been different had respondent examined her wound on July 31, 2014, considering that Patient A was at high risk of complications due to her age and the hip surgery she underwent.

[9] Respondent's note was also inaccurate because he failed to identify that the source of this information was Patient A's son.

Regarding the question of respondent's follow-up with the skilled nursing facility, here Dr. Deckey's testimony is found to be more persuasive than Dr. Missiarian's testimony. Dr. Deckey credibly testified that respondent could rely on the facility's nurse practitioner, wound care nurse, nursing staff and the facility doctor, Dr. Baroudi, to assess Patient A's condition and report to him if Patient A's condition changed. Saliently, Dr. Deckey stated that Patient A was discharged to a skilled nursing facility in order to be monitored and protocols were in place to help ensure Patient A's monitoring.

Further, in contrast to Dr. Deckey's credible testimony on this topic, Dr. Missiarian's testimony that respondent was required to "create" communication was vague. It is not clear what the nature of this "created communication" he referenced with the skilled nursing facility should have entailed: namely, how often respondent should have contacted the facility, when he should have contacted the facility, whether there were protocols in place that required the facility to contact respondent, and how respondent's communication should have worked as a practical manner.

In addition, it is further found that Dr. Deckey's testimony was more persuasive than Dr. Missiarian's with respect to Dr. Missiarian's opinion that respondent was required to sign Nurse Practitioner's July 10 and 11, 2014, notes in which she informed respondent of Patient A's condition. Complainant did not dispute Dr. Deckey's testimony that the standard of care did not require respondent to cosign the notes because a physician needs to sign only five percent of such notes as long as there is a protocol with the nurse practitioner with the supervising physician. At any rate, the purpose of Ms. Anderson's notes was to document that she reported Patient A's condition to respondent. There was nothing unclear about what she reported, that she was reporting Patient A's condition, and respondent did not create the notes. In both notes, Ms. Anderson documented that she discussed Patient A's condition with respondent.

Testimony of Experts Regarding Patient B

32. The parties stipulated to the admission of a declaration dated October 5, 2018, and a report dated February 11, 2018, prepared by Hoang N. Tran, M.D., complainant's expert regarding Patient B, in lieu of his testimony at the hearing regarding Patient B.

Dr. Tran graduated from Harvard Medical School in 1993 and completed his residency in Orthopedic Surgery at the University of California, San Diego in 1998. He completed a fellowship in Hand Microvascular Surgery in 1999. Since 1999, he has been Director of the Orthopedic Surgery Service, Orthopedic Hand & Upper Extremity Surgery, at Woodland Memorial Hospital. Dr. Tran is certified by the American Board of Orthopedic Surgery.

In preparing his report regarding Patient B, he reviewed the evidence of record in this matter including the QME reports respondent prepared, and he listened to respondent's October 12, 2017, interview with the Health Quality Inspection Unit regarding the reports he prepared for Patient B.

Dr. Tran identified the applicable standard of care as follows: "The quality of the Qualified Medical Evaluation relies on the quality of the medical records available for review. The Standard of Care is to review all medical records pertinent to the patient's care for the work related injury. The Standard of Care is to exclude medical records that do not belong to the patient."

Dr. Tran concluded that respondent departed from this standard of care. He wrote the following regarding his conclusion that respondent committed a simple departure from the standard of care: "(i)n performing a Qualified Medical Examination for [Patient B], "Dr. Moazzaz has an obligation to ensure the medical records that he reviews for [Patient B] are her records and only her records."

By means of a declaration he prepared dated October 5, 2018, Dr. Tran addressed Dr. Deckey's anticipated testimony regarding Patient B. He stated the following after reviewing Dr. Deckey's report, in relevant part: "my opinion has not changed because Dr. Moazzaz should have obtained a medical history as part of the evaluation. If Dr. Moazzaz had obtained a medical history by talking to the patient, he would have discovered that clerical error. Because he did not obtain a medical history, this is a simple departure from the standard of care."

TESTIMONY OF DR. DECKEY REGARDING PATIENT B

33. Dr. Deckey testified that he has served as a QME but presently does not work as one. He is familiar with QME evaluations and how they are conducted. Dr. Deckey prepared a report and that report is consistent with his testimony at this hearing.

Dr. Deckey disagreed with Dr. Tran's conclusion that respondent committed a departure from the standard of care with respect to Patient B. Dr. Deckey emphasized that the "clerical errors" respondent made in his report did not represent departures from the standard of care. He made his conclusion because as a QME respondent was not in a treatment capacity with Patient B and was not determining the treatment Patient B was to be given. He was performing a medical legal evaluation of Patient B for purposes of an independent medical legal evaluation of her orthopedic condition as a workers' compensation claimant.

Dr. Deckey added that respondent acted reasonably to correct the errors in his reports once he became aware that Patient B's records were mixed up with another workers' compensation claimant's records.[10] Dr. Deckey also noted that once respondent became aware that he mistakenly included three doctors Patient B had not seen in the second revised report respondent offered to reevaluate Patient B and further revise the report. He

[10] Steve Ounjin, owner of the service that provided respondent with online access to Patient B's records, testified at this hearing regarding the nature of the clerical error. His testimony is summarized later in this decision.

commented, contrary to Dr. Tran's assertion, that respondent did take a history of Patient B and conducted a physical examination of her.

EVALUATION REGARDING THE EXPERTS' OPINIONS RELATING TO PATIENT B

34. Dr. Deckey's opinion that respondent did not breach the standard of care when he included the names of three doctors that were not Patient B's doctors in his report is found to be more persuasive than Dr. Tran's opinion that respondent departed from the standard of care. This conclusion is reached for the following reason: In his October 5, 2018, declaration Dr. Tran did not address Dr. Deckey's opinion that because respondent was not in a "treatment capacity" with Patient B the clerical errors he committed did not represent departures from the standard of care. In his report Dr. Tran identified the standard of care as applicable to a "patient," and he continued to refer to the standard as applicable to a "patient" in his declaration. He did not, moreover, define what he meant by "patient" in the standard of care he identified, as it related to respondent as an evaluating doctor for Patient B. Because Patient B was not respondent's patient, as Dr. Deckey testified, the standard of care Dr. Tran identified does not apply to respondent's evaluation of Patient B.[11,12]

Regardless, and with this noted, respondent took appropriate steps as a reasonably prudent physician to mitigate the clerical error he made in his second revised report. Once he learned that he incorrectly included three doctors in this report he offered to conduct another evaluation of Patient B and prepare a further report.

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[11] Dr. Tran did not testify in this proceeding and an inference is drawn that had he testified he would have provided testimony that was helpful to respondent's response regarding the standard of care he identified in his report. (Evid. Code, § 412 ("If weaker and less satisfactory evidence is offered when it was within the power of the party to produce stronger and more satisfactory evidence, the evidence offered shall be viewed with distrust.").)

[12] To assess the applicability of the standard of care Dr. Tran identified in his report, the distinction between treating and non-treating or evaluating doctors is important to understand. In the context of the weight to be given the opinions of treating and non-treating physicians in Social Security cases, the Court of Appeals for the Ninth Circuit has provided the following useful definition of treating doctor: "he [*sic*] is employed to cure and has a greater opportunity to know and observe the patient as an individual." (*Winans v. Bowen* (1987) 853 F.2d 643, 647 (citations omitted).) By this definition, respondent was not treating Patient B to cure her, but was employed to evaluate her for purposes of the apportionment of her workers' compensation claim.

Respondent's Evidence

RESPONDENT'S TESTIMONY

35. Respondent graduated from the University of California, Davis, School of Medicine in 2006 and completed an Orthopedic Surgery Residency at University of California, Los Angeles in 2010 and the San Diego Spine Fellowship at Scripps Clinic in 2011. Since 2011, respondent has worked at Orthopaedic Specialists of North County. He is a staff surgeon at Tri-City Medical Center, Scripps Memorial Hospital and Carlsbad Surgery Center. Respondent is also Chairman of the Tri-City Medical Center Department of Surgery and Chairman of the Tri-City Medical Center Operating Room Committee. Respondent is an attending board certified orthopedic spine surgeon. He has been a presenter on topics related to spinal surgery including robotics surgery, has authored articles relating to spine surgery and has dedicated himself to the area of robotic surgery where he has held faculty teaching positions for visiting surgeons. Since 2011, he has performed numerous spine and hip surgeries and he estimates he performs between five to six surgeries per week with a majority of his patients in the elderly population. Since 2013 respondent has been certified as a QME.

36. Respondent testified regarding his treatment of Patient A and the reports he prepared for Patient B as a QME.

Regarding his care and treatment of Patient A, respondent stated that the patient did surprisingly well after the July 9, 2014, surgery and he visited her at the hospital after rounds. Respondent worked closely with Nurse Practitioner Anderson, who was a hospital employee who supervised nursing assistants, wrote discharge summaries and did rounds. She had the responsibility to see patients daily and assess their progress.

After her surgery, respondent determined that Patient A needed to be discharged to a skilled nursing facility and she was discharged to Vista Knoll. He issued a post-operative order to have her follow up with him in two weeks and have x-rays done and brought with her to her appointment. The x-rays were done at the skilled nursing facility. Respondent stated that he did not customarily see patients at the skilled nursing facility after their discharge.

On July 24, 2014, respondent was contacted about irritations around Patient A's incision and he ordered that she be placed on Keflex, an antibiotic, just in case there was an infection. He commented that any infection is typically topical with redness around staples. A deeper infection presents with discharge from the incision and the patient has a fever. Respondent said often patients develop redness around staples and the staples typically are removed between 10 to 14 days after surgery. On July 24, 2014, respondent recalled that he asked nursing staff at the skilled nursing facility whether Patient A had a fever or discharge.

After July 24, 2014, the skilled nursing facility did not call respondent, and he did not call the facility in turn. In retrospect, respondent admitted he wished he had called. Regardless, respondent expected that if there was a change in Patient A's condition Dr.

Baroudi or a nurse at the facility would have contacted him, especially if Patient A had a fever or drainage.

37. Respondent recalls seeing Patient A on July 31, 2014, with her son at his office. He described her as "pretty out of it" with delirium. Respondent said he was running behind that day and Patient A's son was upset he and his mother had to wait so long. He acknowledged that Patient A and her son were waiting for an extended time period.

Customarily, his practice would have been to look at the incision and take out the staples. However, based on what he was told on July 31, 2014, Patient A's son refused to have her lifted on table and have the staples taken out; he wanted to take her back to the facility to go back to bed. Respondent did not press the issue. He acknowledged that he should have pressed the issue.

Respondent also acknowledged that the documentation of his visit with Patient A was "very poor." He did not examine the wound and, instead, obtained from Patient A's son that she had no fever or drainage, which he recorded in the "Interim History" section of his July 31, 2014, record. Respondent inaccurately recorded under the "Physical Exam" section of his July 31, 2014, report that Patient A's surgical incision was "healing well with no erythema or drainage" because he was using a template. On cross examination he acknowledged that had he examined the wound he would have seen drainage. Respondent noted that he looked at the x-ray of Patient A's hip which showed it was properly placed and post-visit he developed an appropriate plan for Patient A's treatment at the skilled nursing facility.

38. When respondent returned from vacation he learned from Dr. Baroudi that Patient A had passed away. He looked back at his report and testified he was "horrified" and "sick to his stomach" about what happened to Patient A at the hospital while he was on vacation.

Respondent said he was really affected by what happened to Patient A and knows he should have done better. He has taken steps to improve his practice and believes that he has improved professionally and personally. To improve his medical record keeping, starting in 2015, respondent hired a medical assistant, Mina Gardezi, to serve as a medical record scribe to help him with documentation. Ms. Gardezi, a graduate of the University of California, San Diego, followed him as he examined patients and documented his discussions with patients, their medical histories, significant findings and results of imaging studies. Ms. Gardezi then imported these findings into the patients notes and plan, and respondent then edited them and signed off on them. After Ms. Gardezi left to go to graduate school in April 2018, respondent hired another person to act as a scribe.

Respondent also attended and completed at the University of California, San Diego, School of Medicine's Physician Assessment and Clinical Education Program (PACE), a medical record keeping course from July 26 to 27, 2018. On April 5, 2018, respondent enrolled in PACE's Physician Competence Assessment program. He testified he is in the

process of completing forms he is required to submit, including a Root Analysis form and Chart Review Instructions. To improve his communication skills, respondent intends to take PACE's Clinician-Patient Communication Workshop on October 20, 2018.

Respondent testified that now he has really changed his habits and practice. He is more available to take calls regarding patients; he gives out his cell phone number to nurses, staff and caregivers; and he visits skilled nursing facilities to examine patients. Respondent commented that caregivers now call him daily.

Respondent emphasized that he has worked very hard to prevent infections in surgical patients and his rate of infections from 2017 to 2018 is zero. He took obvious pride in this low infection rate. In 2014 and 2015 the rate of infection was one to two percent.

39. Regarding Patient B, respondent stated that he became certified as a QME in 2013 and performs evaluations throughout California and in the Central Valley in Northern California. He regularly sees numerous examinees in Fresno and San Diego, reviews medical records, performs examinations and prepares reports. In 2018, he estimated he conducted two to three hundred evaluations. Since 2013, he has conducted over 1,000 QMEs.

As a QME respondent works with California Medical Legal Specialists (CMLS), a company that coordinates with examinees, lawyers and QMEs, obtains medical records, and provides medical evaluators, through an online secure website, access to the medical records for their review.

Respondent testified that his role in evaluating Patient B, as a QME, was to provide medical legal conclusions based on the examination he conducted and history he obtained from the medical records. He was not treating Patient B. Before he conducted the examination Patient B completed a questionnaire regarding her medical history which respondent reviewed. He spent about 60 minutes with Patient B, six hours of record review, two to three hours of medical research, and about three hours preparing the report. His review, he noted, must be completed within 30 days.

40. Respondent acknowledged that there were errors in his report because Patient B's records were mixed up with those of another patient who had, oddly, a similar profile. Respondent said the records were over 1,000 pages. The records were mixed up because an employee, according to Steve Ounjin, owner of CMLS, had scanned Patient B's records together with this other patient's records and uploaded the records in the database under Patient B's secured file which respondent had access to review. Mr. Ounjin testified that these numerous records were "pancaked together." Respondent then reviewed these records as part of his evaluation.

When respondent learned that there were errors in his report, he re-reviewed the records to make sure he was reviewing the correct records and prepared a new report dated July 8, 2017. In this new report, respondent inadvertently carried over from the previous report the names of doctors that Patient B had not seen. When respondent became aware of

these errors, he tried to reschedule Patient B for a reevaluation. The reevaluation was scheduled and then cancelled. He prepared and signed a final or re-revised report for Patient B on December 25, 2017. Based on this final report there were no changes in apportionment, causation, work restrictions, future medical care or whole person impairment.

41. Respondent stated that he learned from his mistake relating to Patient B's evaluation and the reports he prepared that contained incorrect information. He is more diligent in doing QMEs and he believes the quality of his work has improved.

42. Respondent's testimony was credible. He acknowledged his mistakes treating Patient A and in preparing the QME reports for Patient B; he credibly took responsibility for failing to examine Patient A's wound on July 31, 2014, failing to accurately document the condition of the wound; and including incorrect medical information in Patient B's QME reports. Ms. Gardeni's testimony, documentation regarding the PACE courses he has taken, and the testimony of Steve Ounjin, which is detailed immediately below, substantiate respondent's testimony regarding his efforts to ensure that he does not make the mistakes that have been identified in the accusation again.

TESTIMONY OF STEVE OUNJIN

43. Steve Ounjin is the owner of California Medical Legal Services (CMLS), a company that provides workers' compensation support services for applicants and the insurance defense industry. CMLS works with QMEs throughout California, schedules evaluations, obtains medical records and provides these medical records to QMEs through a secure server which QMEs can access. Mr. Ounjin testified relating to the QME respondent performed on Patient B, respondent's work as a QME and substantiated respondent's testimony relating to Patient B. Mr. Ounjin testified that the medical records CMLS receives are typically voluminous, a "mixed up mess," as he put it, and poorly indexed or not indexed. He said that an employee had mixed up Patient B's records with the records of another patient and uploaded these mixed up records to Patient's B's file.

Through his work at CMLS arranging workers' compensation evaluations for workers' compensation claimants since the 1980s, Mr. Ounjin is familiar with the procedures for workers' compensation evaluations through the Division of Workers' Compensation. He said that often there are errors in the medical records they review, and the records are often a "mixed up mess" without indexing. When there is a clerical error, as was the case here, the most common process through the Division of Workers' Compensation is to a request a supplemental report. Another less common way to correct a factual error is for the party to ask the QME to prepare a supplemental clarification using a QME Form 37 (10/2013) captioned "Request for Factual Correction of an Unrepresented QME report." A copy of this form was made part of the record.

Mr. Ounjin testified that he talked to respondent about the mistakes in his report, respondent has taken the mistakes in his report very seriously, respondent has changed his practice of reviewing records, and he has worked with CMLS to make sure they are not

repeated. Now, CMLS ensures that examinees records are bundled separately before they are scanned into the system. As an example of the efforts CMLS has made in this regard to identify instances where records are incorrectly bundled Mr. Ounjin stated he gives bonuses to staff who discover mistakes in records submitted for QME review.

Mr. Ounjin also discussed respondent's reputation as a QME. He stated that respondent has an excellent reputation as a QME in the industry and both applicant and defense attorneys seek him out to conduct evaluations. As a result, respondent gets a tremendous amount of appointments to conduct evaluations because of the timeliness and quality of the evaluations he conducts. He now serves an Agreed Medical Evaluator, which means that, due to his excellent reputation, both applicant and defense attorneys have asked him to evaluate a claimant's orthopedic condition for workers' compensation purposes.

TESTIMONY OF RICHARD SMITH, M.D.

44. Richard Smith, M.D., testified as a character witness for respondent. He is the Director of Infection Control at Tri-City Medical Center. He is board certified in Internal Medicine and Infectious Diseases. At Tri-City he serves as a consultant on infectious diseases relating to patients who are very ill and have infections. Dr. Smith has known respondent professionally for the last five years.

Dr. Smith testified that based on his review of infection rates at Tri-City the rate of infections for respondent's patients are very low with zero infections in 2017 and 2018. He, further, regards respondent as an excellent surgeon and would select him to act as his personal surgeon or the surgeon for family members.

Dr. Smith knows about the allegations in the accusation against respondent and hopes that respondent will be able to continue to provide medical care to patients.

TESTIMONY OF GENE MA, M.D.

45. Gene Ma, M.D., is an emergency room physician at Tri-City and has known respondent professionally for the last six years and testified on respondent's behalf as a character witness. Dr. Ma is aware of the allegations in the Accusation.

Over the last 14 years Dr. Ma has been involved in overseeing quality of care at Tri-City as Chairman of Emergency Medicine, Chairman of Quality Assurance, and as a member of the Medical Executive Committee. Recently he served as Chief of Staff. In addition to his testimony, Dr. Ma submitted a letter dated August 4, 2018, which was admitted as evidence.

Over the last six years, Dr. Ma has had a professional working relationship with respondent through shared patients and through the Medical Executive Committee where respondent was elected to serve as a member. Dr. Ma stated that respondent was elected to the Committee because he was seen as a rising star in the Tri-City medical community.

Dr. Ma described respondent's skills as a surgeon as "outstanding in every way." In his letter, he described respondent "as one of the most technically proficient surgeons on our staff with superb clinical outcomes" and stated that respondent has advanced the health and wellness of the community by introducing minimally invasive modalities at the hospital, pioneering the growth of the hospital's robotics programs. Dr. Ma added in his testimony that respondent is very professional with staff and patients, always willing to respond and take calls, and respondent always puts patients first. Dr. Ma stated that he is confident that when respondent responds to a call he can tell the patient that he or she has a doctor of the highest quality.

TESTIMONY OF NEVILLE ALLEYNE, M.D.

46. Neville Alleyne, M.D., also testified on respondent's behalf as a character witness. In addition to his testimony he prepared a letter dated August 1, 2018, which was admitted as evidence.

Dr. Alleyne is the Chief of Orthopedics at Tri-City Medical Center and the president of Orthopaedic Specialists of North County. He has known respondent for seven years and is aware of the allegations in the Accusation against him.

Dr. Alleyne described respondent's surgical skills as "outstanding" and "superior." Based on his working with surgeons for over 30 years he said respondent has some of the best surgical skills he has ever seen. He said that he was very fortunate to have respondent in his practice and he emphasized that respondent brought robotics into the practice and Tri-City was the fourth hospital in the county to use robotics for surgery.

Dr. Alleyne has had the chance to observe respondent's interactions with patients and their families. As he put it, he has less anxiety when respondent is on call because he is meticulous in terms of his care of patients. Respondent always checks in with patients, even on weekends, and patients and their families are grateful for the medical care he provides.

Dr. Alleyne testified that respondent has made changes to his practice since Patient A's death. He noted that respondent now has a medical records scribe and respondent has improved his communication with patients.

Dr. Alleyne, also, emphasized that respondent has a very low rate of infection in the patients he treats. He said that respondent has the lowest infection rate in San Diego County.

The testimony of Drs. Smith, Ma, and Alleyne were fully credible.

LETTERS SUBMITTED AS EVIDENCE BY STIPULATION OF THE PARTIES

47. The parties stipulated that the letters from the following individuals be admitted as direct evidence: Mark Yamanaka, M.D., dated August 3, 2018; David Amory,

M.D.; Eunice Rodriguez, dated August 5, 2018; Lori Fisher, MSN, dated August 2, 2018; and an undated letter from Patrick Nolan, RN.

Dr. Yamanaka is Medical Chief of Staff elect at Tri-City and has known respondent since 2011. In his letter Dr. Yamanaka stated he is familiar with the allegations in the Accusation against respondent. He described respondent as an intelligent, capable and empathetic doctor with excellent skills, technical abilities and communication abilities. He believes that respondent has grown from his experience with Patient A and has improved his documentation. Dr. Yamanaka noted that respondent's infection rate is very low.

Dr. Amory has been respondent's colleague at Orthopaedic Specialists of North County for six years both in the clinical practice of orthopedics and as a QME. He described respondent as an extremely caring, competent and meticulous physician who has been a pioneer in the use of Mazor Robotic Surgery. Dr. Amory also had personal knowledge of Patient A and described his involvement in her care on August 1, 2014, consistent with the record.

Ms. Rodriguez is a medical assistant at Orthopaedic Specialists of North County and has worked with respondent for four years. She knows about the allegations against respondent in the Accusation. In her letter Ms. Rodriguez described respondent as thorough, patient, understanding and compassionate with patients with a very high success rate.

Ms. Rodriguez also described in her letter the circumstances regarding Patient A's July 31, 2014, office visit with respondent based on her personal knowledge. Essentially, she substantiated respondent's testimony that Patient A's son declined to have Patient A taken out of the wheelchair and transferred to the exam table and Patient A's son was present during the consultation with respondent.

Ms. Fisher in her letter stated that she has worked closely with respondent as a nurse on multiple occasions since 2011. She is aware of the allegations against him in the Accusation. She described respondent as one of the best surgeons she has worked with and she has absolute faith in his clinical skills. She described him as ethical, compassionate and caring with excellent interpersonal skills.

Mr. Nolan has worked with respondent at La Paloma Healthcare Center as a wound care nurse for the last four years. He stated in his letter that he is aware of the Accusation against respondent. Mr. Nolan stated that he has collaborated with respondent regarding the care of many patients at his facility. He described respondent as friendly, proactive, always available and supportive in all matters relating to patient care. He said he is able to reach respondent on respondent's cell phone and he updates respondent on the patients, the appearance of surgical incisions, medications, antibiotics, treatment and the patients' overall well-being. He noted that respondent has advised him that there is a wound care nurse available for consultation and respondent has followed-up and rounded on patients with more pressing issues or concerns.

Mr. Nolan added that he has only seen two doctors who would come in to the facility and check in on their patients and respondent was one of them.

The statements of these individuals are fully credited.

CHARACTER REFERENCE LETTERS

48. Respondent also submitted the following character letters from the following health care professionals which were admitted as administrative hearsay: Victor Souza, M.D., Robert Mongeon, M.D., Beth Jaramillo, AuD, Erin C. Heinle, M.D., Thomas T. Terramini, M.D., Serge Kaska, M.D., Yogesh Patel, M.D., Kaveh S. Farhoumand, D.O., Theodore L. Folkerth, M.D., and Jozzelle LaFortesa, DNP. In summary, these individuals described respondent as a competent, caring and well respected surgeon with excellent clinical and technical skills. Other than Dr. Mongeon, these persons stated that they were aware of the allegations in the Accusation against respondent. Their opinions of respondent supplement and explain respondent's testimony and the testimony of Drs. Smith and Alleyne that respondent is a competent, highly skilled and respected surgeon in the community.

49. Respondent also submitted letters from the following attorneys at law who have worked with respondent in his role as a QME: John Mullen, Darin Powell, William Toppi, Brynn Anne Gruenberg, Edward C. Valdez, Dennis K. Thomas, Rene F. Zuzuarregui, Ali Golchin, Mary McLauglin Davis, Susan Lavian, Mark Derzon, and Jennifer Kwon. In summary, these individuals attested that respondent in his role as a QME is professional and fair and well respected as a QME. However, these persons did not state that they were aware of the allegations in the Accusation involving Patient B and their opinions of respondent as a QME are not fully credited.

Respondent additionally submitted letters of support from persons who work in the workers' compensation insurance industry: Donna Ball, Andria Cselovszki, Sue Creighton, Keenan Hurley and James B. Linne. In summary, these persons attested to the quality, timeliness and thoroughness of the reports respondent prepared as a QME and his professionalism and attention to detail. Again, however, these persons did not state they were aware of the allegations in the Accusation involving Patient B and their opinions of respondent as a QME are not fully credited.

The Parties' Arguments

50. Complainant asked that due to the departures identified in the hearing respondent should be placed on probation consistent the Board's Disciplinary Guidelines. Complainant asked that that the following terms and conditions be imposed: five-year probation with education and medical record keeping courses (Conditions 13 and 15), the requirements that he attend and successfully complete a clinical competence assessment program (Condition 18), have a practice monitor (Condition 23), and be prohibited from engaging in the solo practice of medicine (Condition 24), in addition to standard terms and conditions.

Respondent argued that the evidence did not establish that respondent committed gross negligence, he has learned from the mistakes he made, has taken full responsibility for his conduct, and has undertaken affirmative steps to change his practice to ensure that he does not repeat the same mistakes again. Respondent asked that he be issued a public letter of reprimand.

In reply, complainant argued that a public reprimand is inappropriate because the evidence showed that respondent committed gross negligence, not repeated negligent acts, and a public reprimand is appropriate only for "minor" violations of the Medical Practice Act under Section 2234.

LEGAL CONCLUSIONS

Purpose of Physician Discipline

1. The purpose of the Medical Practice Act is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.)

The purpose of administrative discipline is not to punish, but to protect the public by eliminating those practitioners who are dishonest, immoral, disreputable or incompetent. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.)

Standards of Proof

2. The standard of proof in an administrative action seeking to suspend or revoke a physician's certificate is clear and convincing evidence. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

Applicable Statutes Regarding Causes to Impose Discipline

3. Business and Professions Code section 2227, subdivision (a), states:

> A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the board.

(2) His or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to the discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

4. Business and Professions Code section 2234 provides in part:

The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

[¶] . . . [¶]

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon. . . .

5. Business and Professions Code section 2266 provides:

The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

Public Letter of Reprimand

6. Business and Professions Code section 2233 provides as follows:

> The board may, by stipulation or settlement with the affected physician and surgeon, issue a public letter of reprimand after it has conducted an investigation or inspection as provided in this article, rather than filing or prosecuting a formal accusation. The public letter of reprimand may, at the discretion of the board, include a requirement for specified training or education. The affected physician and surgeon shall indicate agreement or nonagreement in writing within 30 days of formal notification by the board of its intention to issue the letter. The board, at its option, may extend the response time. Use of a public reprimand shall be limited to minor violations and shall be issued under guidelines established by regulations of the board.

Decisional Authority Regarding Standards of Care

7. The standard of care requires the exercise of a reasonable degree of skill, knowledge, and care that is ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care involving the acts of a physician must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal. App. 4th 310, 317.) It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal. App. 4th 234, 280.)

8. The courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal. App. 3rd 1040, 1052. Simple negligence is merely a departure from the standard of care. (*Id.* at 1054.)

Case Law Regarding Unprofessional Conduct

9. In *Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575, the appellate court noted that "unprofessional conduct" as that term was used in Business and Professions Code section 2361 (now section 2234), included certain enumerated conduct. (*Id.* at p. 575.) The court further stated (*Ibid.*):

> This does not mean, however, that an overly broad connotation is to be given the term "unprofessional conduct;" it must relate to conduct which indicates an unfitness to practice medicine. [Citations.] Unprofessional conduct is that conduct which breaches the rules or ethical code of a profession, or conduct which is unbecoming a member in good standing of a profession. [Citation.]

Cause Exists, in Part, Under the First Cause for Discipline to Impose Discipline Against Respondent's License for Conduct Constituting Gross Negligence

10. Cause exists to impose discipline on respondent's medical license pursuant to Business and Professions Code section 2234, subdivision (b), gross negligence, relating to respondent's care and treatment of Patient A.

Clear and convincing evidence established that respondent falsely recorded in Patient A's medical record that her surgical incision was "healing well with no erythema or drainage" based upon the credible testimony of Dr. Missiarian as substantiated in the record as a whole.

Clear and convincing evidence established that respondent provided inadequate follow-up care after her left hip surgery based upon the credible testimony of Dr. Missiarian as substantiated in the record as a whole. Respondent failed to examine Patient A's surgical wound site or try to convince Patient A's son of the importance of examining her wound.

Clear and convincing evidence did not establish that respondent's communication with the skilled nursing facility fell below the standard of care based upon Dr. Deckey's credible testimony as substantiated in the record as a whole.

Cause Does Not Exist Under the Second Cause for Discipline to Impose Discipline Against Respondent's License for Conduct Constituting Repeated Negligent Acts

11. Clear and convincing evidence did not establish that respondent committed repeated negligent acts in the care and treatment of Patient A on July 31, 2014. Respondent's conduct falsely recording Patient A's condition and failing to provide inadequate care constituted a single act of negligence.

Clear and convincing evidence, in turn, did not establish that respondent departed from the standard of care Dr. Tran identified regarding respondent's evaluation of Patient B based upon Dr. Deckey's credible testimony as substantiated in the record as a whole.

Cause Exists, in Part, Under the Third Cause for Discipline to Impose Discipline Against Respondent's License for failing to Maintain Adequate and Accurate Records

12. Clear and convincing evidence established that respondent failed to maintain adequate and accurate records regarding his care and treatment of Patient A based upon Dr. Missiarian's credible testimony as substantiated in the record as a whole. Clear and convincing evidence did not establish that respondent failed to maintain adequate and accurate records regarding his care and treatment of Patient B based upon Dr. Deckey's credible testimony as substantiated in the record as a whole.

Cause Exists under the Fourth Cause for Discipline to Impose Discipline Against Respondent's License for Unprofessional Conduct

13. Clear and convincing evidence established that respondent engaged in conduct that breached the rules or ethical code of the medical profession which is unbecoming to a member of the medical profession and demonstrates potential unfitness to practice medicine based upon the conclusions reached finding causes for discipline for gross negligence and inadequate and inaccurate record keeping.

The Board's Disciplinary Guidelines and Evaluation Regarding the Degree of Discipline

14. The Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th Edition 2016) states:

> The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake Board-ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

For the violations established relating to respondent's misconduct regarding the treatment of Patient A, the Board's disciplinary guidelines provide for a minimum penalty of a stayed revocation with a probationary period of five years and a maximum penalty of revocation with terms and conditions that include Education, Prescribing Practices and/or Medical Record Keeping Courses (Conditions 13, 14 and 15), a Professionalism Program (Ethics Course) (Condition 16), a Clinical Competence Assessment Program (Condition 18), Monitoring-Practice (Condition 23), Solo Practice Prohibition (Condition 24), and Prohibited Practice (Condition 26).

Disciplinary Considerations and Disposition Regarding the Degree of Discipline

15. The purpose of an administrative proceeding seeking the revocation or suspension of a professional license is not to punish the individual; the purpose is to protect the public from dishonest, immoral, disreputable or incompetent practitioners. (*Ettinger, supra,* 135 Cal.App.3d at 856.) Rehabilitation is a state of mind and the law looks with favor upon rewarding with the opportunity to serve one who has achieved "reformation and regeneration." (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1058.) The determination whether respondent's license should be revoked or suspended includes an evaluation of the rehabilitation and mitigation factors.

After considering the Board's guidelines, the evidence of rehabilitation and mitigation and the evidence of record as a whole, it is determined that a period of probation with appropriate terms and conditions to protect the public is warranted. Respondent's request that a public reprimand be issued for his conduct is denied. This determination is made for the following reasons.

Respondent's conduct relating to his care of Patient A on July 31, 2014, was serious and exposed Patient A to potential life threatening harm. Considering that the sole purpose of seeing Patient A on July 31, 2014, was for respondent to examine Patient A's wound post-surgery, and also that he made aware on July 24, 2014, that she had an infection, his misconduct reflected poor judgment on multiple levels: Respondent failed to examine Patient A's wound, he relied on Patient's A's son's characterization of her wound, he failed to document that he did not examine the wound and, further, he failed to try to convince Patient A's son or Patient A of the importance of his examining the wound. Here, it must be kept in mind that Patient A was 91 years old and recovering from hip surgery, a high-risk procedure for a person her age. She was unable to speak for herself, and respondent had a duty to do more than run through the paces during the July 31, 2014, office visit to ensure her well-being. The fact that her son wanted her to return to the skilled nursing facility cannot be considered a mitigating factor, as respondent argued, considering Patient A's vulnerability, the purpose of the visit, and respondent's duty to chart her care adequately and accurately. As Dr. Missiarian stated, respondent should have tried to persuade her son of the importance of examining the wound and, at the very least, documented that despite his efforts, Patient A and her son declined.

With this stated, respondent presented sufficient evidence of rehabilitation that departure from the recommended penalty range for respondent's conduct in the Guidelines is warranted. At the same time, considering the nature and severity of respondent's misconduct, issuance of a public reprimand is not appropriate, as respondent requested. The conclusion regarding the degree of penalty to impose is supported by the following evidence: Respondent accepted full responsibility for his conduct and he appeared chastened by his failure to provide adequate care and treatment for Patient A. Respondent has, further, taken substantial steps to ensure that he does not make the same mistake again. He has employed a medical record scribe since 2015, he has improved his record keeping, and he has completed medical record keeping courses and stated he intended to take a client communication workshop. Respondent has no history of discipline; the conduct most likely is an isolated event in his career. In addition, respondent is a recognized leader in the Tri-City medical community, and is committed to the well-being of his patients and patients in the community he serves. The doctors who testified on his behalf at the hearing credibly attested to his commitment to the medical profession, patient care, and his competence as a doctor. Numerous doctors and health care professionals wrote letters on his behalf and described him as professional, caring and committed to his patients.

Accordingly, a departure from the minimum five-year probation period is warranted for respondent's violations of Business and Professions Code sections 2234, subdivision (a), and 2266. A three-year period of probation with the following terms and conditions will

ensure public protection: an Education Course (Condition 13), a Medical Record Keeping Course (Condition 15), a Professionalism Course (Condition 16), and standard terms and conditions. It is not necessary, to ensure public protection, as complainant argued, that respondent be required to enroll in a clinical competence assessment program, that he be prohibited from engaging in the practice, or that he be required to have a practice monitor. Respondent demonstrated that he is a clinically competent doctor and the mistakes he made were not due to his clinical competence or technical skills.

ORDER

Physician's and Surgeon's Certificate No. A100652 issued to respondent Payam Moazzaz, M.D., is revoked. However, the revocation is stayed and respondent is placed on probation for three years upon the following terms and conditions.

1. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. Notification

Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

5. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

6. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

7. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

8. General Probation Requirements

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

9. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

10. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

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11. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

12. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

14. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

DATED: November 9, 2018

DocuSigned by:
Abraham Levy
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ABRAHAM M. LEVY
Administrative Law Judge
Office of Administrative Hearings

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Payam Moazzaz, M.D.** **3905 Waring Road** **Oceanside, CA 92056** **Physician's and Surgeon's Certificate No. A100652,** Respondent.	Case No. 800-2016-020346 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 1, 2007, the Medical Board issued Physician's and Surgeon's Certificate Number A100652 to Payam Moazzaz, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2019, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

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5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

". . .

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

". . . ."

6. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

7. Unprofessional conduct under Business and Professions Code section 2234 is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent has subjected his Physician's and Surgeon's Certificate No. A100652 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient A[1], as more particularly alleged hereinafter:

Patient A

9. On or about July 7, 2014, Patient A was transported to Tri-City Medical Center Emergency Department after suffering a fall. On or about July 8, 2014, Patient A was admitted to the hospital and was seen in consultation by Respondent. Respondent noted Patient A's left leg to be shortened and externally rotated with mild tenderness over the greater trochanter.[2] Upon reviewing Patient A's imaging studies, Respondent recommended a left hip hemiarthroplasty[3] procedure. The wound was irrigated and antibiotic solution and vancomycin[4] powder were placed in the wound bed above the fascial[5] layer.

10. On or about July 9, 2014, under general anesthesia, Respondent performed left hip hemiarthroplasty on Patient A. The surgical wound site was irrigated and vancomycin powder was inserted in the wound bed, before closure of the fascial layer.

11. On or about July 10, 2014 and again on or about July 11, 2014, Respondent evaluated Patient A and found her to be doing well. The medical records for these evaluations were written by R.A., Nurse Practitioner, with no co-signing by Respondent.

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[1] References to "Patient A" are used to protect patient privacy.

[2] Trochanter refers to any of the two bony protuberances by which muscles are attached to the upper part of the thigh bone.

[3] Hemiarthroplasty is a surgical procedure that replaces one half of the hip joint with a prosthetic, while leaving the other half intact.

[4] Vancomycin is an antibiotic used to treat a number of bacterial infections.

[5] Fascia is a thin sheath of fibrous tissue enclosing a muscle or other organ.

12. On or about July 24, 2014, at around 10:00 p.m., the physical therapist called the registered nurse, advising that Patient A had bleeding from her left hip incision site. Upon inspection, Patient A was noted to have a moderate amount of serosanguineous[6] fluid dripping from her incision site and on the bandage. The incision site was red, slightly raised, and well approximated with all staples intact. No streaking, warmth, fever, or swelling around the wound site was noted. Dr. B., Patient A's primary care physician, was notified and Complete Blood Count (CBC), blood metabolic panel, and urinalysis were requested. Respondent was also notified and he ordered Keflex[7] 500 mg, one tablet, four times per day, for seven days.

13. On or about July 24, 2014, at approximately 11:29 p.m., the registered nurse noted Patient A's left hip wound to be red, warm, and draining red serosanguineous fluid and yellow pus at the incision site and bandages were soaked through. Local wound care was performed.

14. On or about July 25, 2014, at approximately 2:09 a.m., the presence of Patient A's left hip infection was again mentioned by the registered nurse. The affected area was kept dry and maintained with clean dressings[8].

15. On or about July 25, 2014, at approximately 11:00 a.m., Patient A's dressings were again changed. By approximately 4:12 p.m., on or about July 25, 2014, Patient A was noted to still have draining of fluid from the incision site.

16. On or about July 25, 2014, at approximately 11:00 p.m., Patient A's dressings were again changed. By July 27, 2014, urine cultures were noted to have grown E. coli[9] and enterococcus[10] and Dr. B. ordered Cipro tablets for Patient A for seven days and discontinued Keflex tablets ordered by Respondent.

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[6] Serosanguineous means containing or relating to both blood and liquid part of blood (serum). It usually refers to fluids collected from or leaving the body.

[7] Keflex is an antibacterial drug used to treat infections caused by bacteria.

[8] A dressing is a sterile pad or compress applied to a wound to promote healing and protect the wound from further harm.

[9] E. coli are a large and diverse group of bacteria. Although most strains of E. coli are harmless, others can make a person sick.

[10] Enterococcus is a large lactic acid bacteria.

(continued...)

17. On Jul 27, 2014, at approximately 4:36 p.m., the Certified Nursing Assistant (CNA)[11] noted a small skin tear on Patient A's left inner buttock. By July 29, 2014, there was an area of denuded skin on Patient A's left buttock, measuring 6.5 c.m. X 1.7 c.m.

18. On or about July 30, 2014, at approximately 12:00 a.m., Patient A was noted to be picking or moving her hip surgery site when asleep in bed. By 8:29 a.m. on July 30, 2014, Patient A's pain level referable to the hip was an eight (8) out of ten (10).

19. Patient A's Complete Blood Count (CBC) had 12.9 White Blood Cell Count (WBC) and wound cultures from Patient A's left hip from July 30, 2014, by August 2, 2014, grew methicillin-resistant *Staphylococcus auresus* (MRSA)[12].

20. No medical doctor had evaluated Patient A's left hip wound since her discharge from Tri-City Hospital on or about July 12, 2014.

21. On or about July 31, 2014, Patient A presented to Respondent's office with her son. Respondent conducted a physical examination of Patient A and on the medical records reflecting this visit, Respondent noted, "her [Patient A's] surgical incision is healing well with no erythema[13] or drainage," which was false. Respondent issued an order for removal of Patient A's skin staples and Steri-Strips[14] applied at the skilled nursing facility and requested Patient A to return in four weeks for repeat hip x-rays.

22. On or about July 31, 2014, upon her return to the skilled nursing facility, at approximately 5:27 p.m., Patient A was complaining of severe pain in her hip, an eight (8) out of ten (10) on a scale of one to ten with ten being most pain. Patient A was given Norco[15] 10/325-

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(...continued)

[11] A certified nursing assistant (CNA) helps patients or clients with healthcare needs under the supervision of a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).

[12] Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium that causes infections in different parts of the body.

[13] Erythema is a superficial reddening of the skin, usually in patches, as a result of injury or irritation.

[14] Steri-Strips are adhesive bandage strips which can be used to close small wounds.

[15] Norco (Hydrocodone Bitartrate and Acetaminophen) is a medication used to relieve moderate to severe pain.

(continued...)

mg tablets. At approximately 9:45 p.m. on July 31, 2014, Patient A was still complaining of severe pain of eight (8) out of ten (10), and she was given Norco 10/325-mg tablets.

23. On or about August 1, 2014, at approximately 9:26 a.m., Respondent's office was notified of the incision site and the drainage. On or about August 1, 2014, Respondent went out of town for a vacation lasting approximately ten (10) days. Patient A's primary care doctor, Dr. B., was contacted. Dr. B. ordered Patient A to be transferred to Tri-City Hospital Emergency Department for further care and treatment.

24. On or about August 1, 2014, at approximately 5:19 p.m., Patient A presented to Tri-City Medical Center Emergency Department. Patient A's white blood cell count (WBC) was 20.9 and she had a temperature of 38.6 degrees, Celsius. Patient A's left hip incision site showed significant copious saturated drainage and foul odor, and new wound cultures were obtained. Respondent's associate, D.A., M.D., evaluated Patient A and she was noted to have frank wound dehiscence[16] with the wound draining focal purulent drainage.[17] D.A., M.D., advised irrigation and debridement[18] and removal of the prosthesis. Patient A's family consented to the surgery. Patient A was admitted to the hospital. After admission to the hospital, Patient A's blood pressure dropped significantly, her condition deteriorated, and she was no longer a surgical candidate. Patient A's family agreed. Patient A expired in the hospital on August 3, 2014, at 9:25 p.m. Respondent learned of these developments, only after his return from his vacation.

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[16] Wound dehiscence is a surgical complication in which a wound ruptures along a surgical incision.

[17] A purulent drainage is a thick and milky discharge from a wound that is often a sign of infection.

[18] Debridement is the removal of damaged tissue or foreign objects from a wound.

25. Respondent committed gross negligence in his care and treatment of Patient A, which included, but was not limited to, the following:

(a) Respondent's medical records reflecting Patient A's follow up visit to him on July 31, 2014 noted, "her [Patient A's] surgical incision is healing well with no erythema or drainage" when this was false;

(b) Respondent had inadequate communication with the skilled nursing facility regarding care and treatment to be provided to Patient A after her left hip surgery; and

(c) Respondent provided inadequate follow up care to Patient A after her left hip surgery.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

26. Respondent has further subjected his Physician's and Surgeon's Certificate No. A100652 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient A and Patient B[19], as more particularly alleged herein.

(a) Paragraphs 9 through 25, above, are hereby incorporated by reference and realleged as if fully set forth herein.

Patient B

27. On or about August 29, 2015, Patient B saw Respondent for a Qualified Medical Evaluation (QME) due to her work injury. Patient B had two dates of injuries, January 17, 2013 and September 25, 2013. Both injuries were related to motor vehicle accidents. After the QME, Respondent issued a report on or about September 6, 2015, which listed fourteen (14) medical providers who never saw Patient B. Thereafter, when above deficiency was raised, Respondent submitted a revised report dated July 8, 2017, in an effort to address the above deficiency. However, this revised report still included three (3) medical providers who were not related to the care of Patient B. Respondent issued a second revised report on or about December 25, 2017.

[19] References to "Patient B" are used to protect patient privacy.

28. Respondent committed repeated negligent acts in his care and treatment of Patient A and Patient B, which included, but were not limited to, the following:

(a) Respondent's medical records reflecting Patient A's follow up visit to him on July 31, 2014, noted, "her [Patient A's] surgical incision is healing well with no erythema or drainage" when this was false;

(b) Respondent's had inadequate communication with the skilled nursing facility regarding care and treatment to be provided to Patient A after her left hip surgery;

(c) Respondent provided inadequate follow up care to Patient A after her left hip surgery; and

(d) Respondent mixed up medical records belonging to another patient and/or other patients with medical records of Patient B in his review and/or drafting of reports issued after performing a QME on Patient B.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

29. Respondent has further subjected his Physician's and Surgeon's Certificate No. A100652 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that respondent failed to maintain adequate and accurate records regarding his care and treatment of Patient A and Patient B, as more particularly alleged in paragraphs 9 through 28, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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FOURTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

30. Respondent has further subjected his Physician's and Surgeon's Certificate No. A100652 to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 9 through 29, above, which are hereby incorporated by reference as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A100652, issued to Payam Moazzaz, M.D.;

2. Revoking, suspending or denying approval of Payam Moazzaz, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Payam Moazzaz, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: March 21, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant